



Module 6

Workers Compensation



Learning Objectives

After completion of this lesson, participants will be able to:

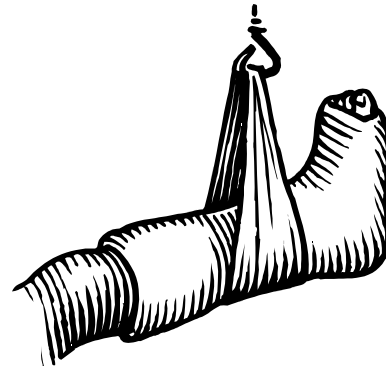
- ☐ Describe the types of Workers' Compensation benefits
- ☐ Describe steps to take when a worker is injured
- ☐ Describe keys to identify possible fraud





About Workers' Compensation

- ❑ The Federal Employees' Compensation Act (FECA), [5 USC 8101et seq.](#), provides compensation benefits to Federal civilian employees (or survivors) for work-related injuries or illnesses
- ❑ Administered by the Department of Labor, Office of Workers' Compensation Programs (OWCP)





About Workers' Compensation (con't)

Basic types of benefits:

- Medical benefits (including transportation expenses)
- Continuation of Pay (COP) (up to 45 days)
- Wage loss compensation
- Scheduled awards
- Vocational rehabilitation
- Survivor benefits if employee dies as a result of injury



Cost of Workers Comp

- Every DAY the Dept. of Defense spends almost 2 million dollars on workers comp
- 80% of this amount goes to “old cases” where the injured employee was never brought back to work.





What can a supervisor do ?

First & Foremost - Prevent injuries

Keep your work area as safe as possible - most workplace injuries are completely avoidable

Enforce all safety rules. Document even verbal warnings about safety violations

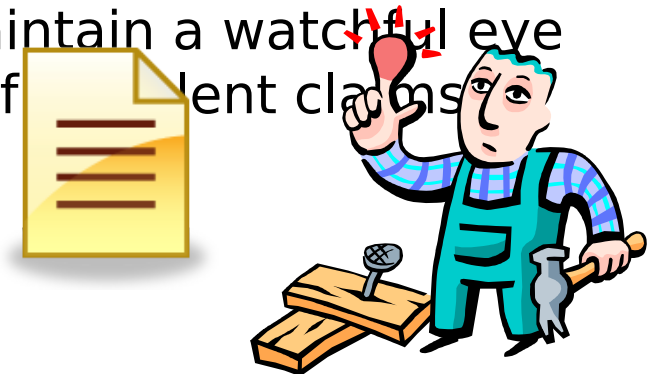
Remember, people pay attention to the example you set

Be prepared with hard copy injury forms (CA-1/CA-2/CA-16, CA-17, CA-20) and learn to input into EDI



The Basics

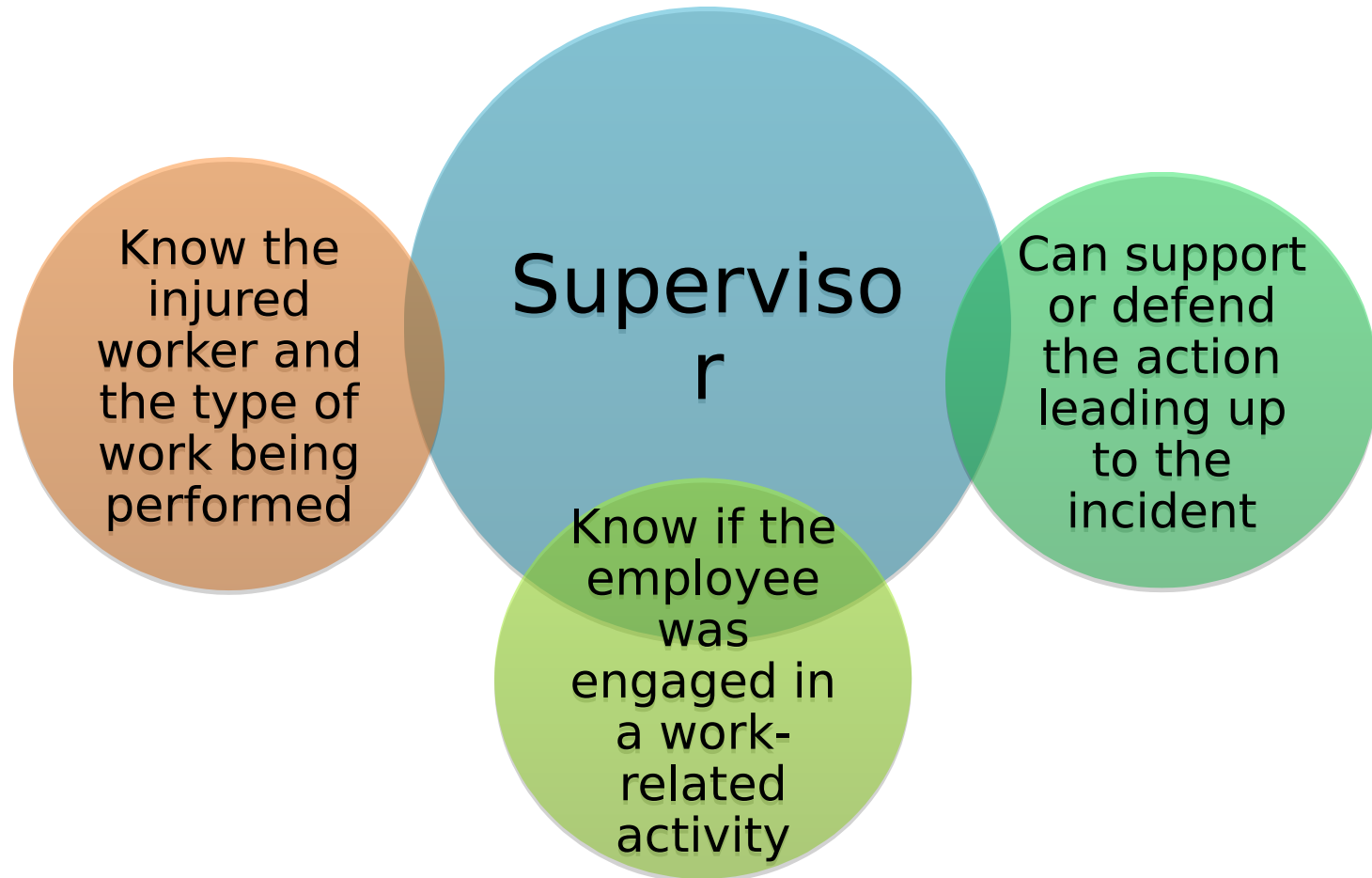
- ☐ Establish a safe work environment
 - ☐ Insure a safety-conscience workforce
 - ☐ Get to know your CPAC Injury Compensation Program Administrator (ICPA)
 - ☐ File claims immediately
 - ☐ Provide prompt medical attention and caring support to the injured/ill worker
- ☐ Investigate the injury – what happened, are others at risk?
 - ☐ Document the events, actions, conditions, witness accounts
 - ☐ Restore the worker to productivity as soon as possible
 - ☐ Maintain a watchful eye for potential claims





Supervisor's Guide to Worker's Comp

You are the most important link to workers compensation because you





Supervisory Responsibilities



Report injuries to the Injury Compensation Program Administrator (ICPA) immediately



Do not block, stop or impede the filing of a claim;



Report information inconsistent with incident leading up to injury



Challenge a claim you suspect is inconsistent with the work you assigned, false, unlikely, or otherwise questionable!



Be Conscience of...

- The same witness for numerous claims
- A witness that typically would not have been in the area of the accident
- An employee with several OWCP claims, the so called "frequent filer"
- An employee with a recent or pending adverse action or nearing the end of a tour, (i.e., term, term indefinite appointment).





What to do when injury occurs

- Furnish hard copies of forms CA-16, CA-17 & CA-20 to the employee. **By law**, you must furnish these forms.
- Input CA-1/CA-2 into EDI.

- Never prevent an employee from getting medical attention even if you don't think it is serious

- Ensure employee seeks medical treatment, such as local clinic, emergency room or private doctor.

- Provide immediate, sympathetic caring environment



Follow-up on an injury

Visit place where injury occurred. Make notes of what happened

Speak with witnesses, ask what they saw & heard.

Speak with Safety Officer about what can be done to ensure this injury never happens again



Input claim into EDI

If you need help on EDI input, consult your ICPA (Injury Compensation Program Administrator) in the CPAC office

If you suspect fraud, indicate in EDI that claim will be challenged

Load claim within 48 hours

Don't hold claim waiting for documentation

Army is tracked on how quickly claims get into EDI

http://www.cpms.osd.mil/ICUC/ICUC_index.aspx



CA-1 or CA-2?

- Traumatic injuries are filed using a CA-1
 - ✓ When a date and time can be specified (cuts, falls, broken bones, etc)
- Occupational illnesses are filed using a CA-2
 - ✓ When an illness or injury happens over the course of a period of time (asthma, carpal tunnel, psychiatric conditions, etc)
- If in doubt- ask your ICPA





Follow up with employee

Phone employee at home

- Ask what limitations doctor placed and why
- When will employee be able to return
- Emphasize light duty, modification of duties
- Emphasize sympathetic caring environment
- If employee must be off more than a week, phone employee every week status
- Remind employee he/she must furnish a medical statement ASAP supporting





Is it “legit” ?

Some Red Flags to be aware of:

- ☐ Unexplained time delay in reporting injury or getting medical care
- ☐ There are no witnesses even though injury happened in area where it should have been observed
- ☐ Witness frequently serves as witness for other injuries
- ☐ Disciplinary action, downsizing, transfer facing employee
- ☐ Injury reported immediately after weekend or holiday
- ☐ Employee changes account of how injury happened





If you spot a “Red Flag”

- Talk to you IPCA; relay your concerns
- Write down all information you have and give to ICPA
- Army has only ONE opportunity to challenge a suspicious claim, and that is before the claim is adjudicated.





Challenging a Suspicious Claim

- Challenge must be based on facts;
being a poor performer is not adequate reason
- Your investigation & notes are crucial
- There is no format or form for a challenge,
 - It is simply a narrative write-up of the facts, signed by you or by the ICPA
 - The suspicious claim you don't challenge may become Army's billion-dollar claim in the future





Timecards

- Day of injury - mark hours missed as LU
- Day after injury, “COP” (Continuation of Payment) begins. COP does not deduct from employee’s leave balances.
- Timecards are marked LT while on COP for the number of days doctor says employee must be off.
- Employee must provide doctor’s written statement, with number of days needed to be off. Be sure ICPA





What if COP is used up ?

- COP is capped at 45 calendar days
- After 45 days, employee can use own leave; pay continues as usual.
- Employee can use LWOP and apply for “compensation” on a [CA-7 form](#)
 - Receives 75% of pay with dependents or 66 2/3% if no dependents. “Compensation” is non-taxable. Be certain which choice employee wants to make.
- Confer with ICPA.



What if employee returns part-time?

- Employee can either use own leave for hours not worked – or can choose LWOP for those hours and claim “compensation” on a CA-7 form.
- Work closely with ICPA to ensure all steps are followed correctly.





What if employee can't do full duties ?

- Sometimes doctor places restrictions on what returning employee can do.
- Must abide by these restrictions !!
- If restrictions are permanent, job may need be assigned to another employee and modified job created for returning employee.
- If restrictions appear unreasonable, work with ICPA to request OWCP
- Get a 2nd medical opinion





Supervisor's final responsibility

- Get injured employee back to work
- If an employee is “out on injury comp” Army pays him. If we don't get employee back, Army pays him for his entire life !!
- If employee returns to work, eventually he retires like the rest of us.
- If employee returns, he is subject to same personnel regulations as other employees.





Can't return ?

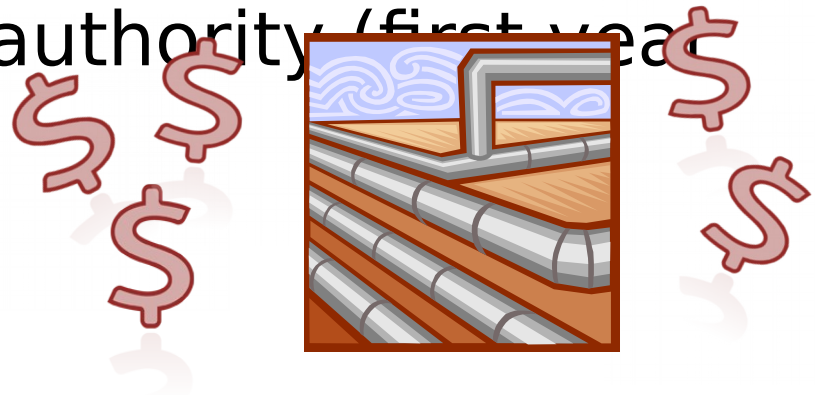
- If employee is never able to meet physical requirements of old job, work with CPAC & ICPA to create a new job within employee's capabilities
- Remember Army is paying employee whether he works or stays home.





DOD's Pipeline Program

- “Pipeline” provides a billet & pays salary for first 365 days for returning employees who have been out for 90 days or more
- DOD transfers money to your activity on a MIPR
- Designed to assist installations in returning employees to work
- Allows for over-hire authority (first year only)





Recap of supervisor's role

1. Prevent injuries
2. Handle injuries correctly if they occur
3. Investigate all facts of injuries and challenge all suspect claims
4. Input claim into EDI or give CA-1/CA-2 to ICPA if you have no computer access
5. ICPA is your partner in all aspects of Workers Comp
6. Getting injured employees back to Army's workforce is a win-win for everyone





Electronic Data Interchange (EDI)

- It has been DoD policy since July 2003 to utilize EDI when submitting claims
- DOL will be monitoring agency timeliness for claim submission as a result of SHARE
- Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim submission



Electronic Data Interchange (EDI)

- Claims filed utilizing EDI are electronically transmitted to OWCP from the agency
- Any delay due to internal routing of paper claims and mailing forms to OWCP are eliminated



Electronic Data Interchange (EDI)

Greater use of EDI



Greater number of timely filed claims



Meeting DoD and SHARE goals



Safety First Electronic Reporting (SAFER)

- DOL has made a determination as to which claim data can be shared with an organization's safety office in order to assist in fulfilling OSHA reporting requirements
- EDI/SAFER provides this data to safety in the form of an OSHA 301 notice. This 301 notice provides safety with the data they need to start their reporting and investigations



Safety First Electronic Reporting (SAFER)

- EDI/SAFER is not a replacement for any existing safety applications or requirements
- Unsanitized copies of CA-1s or CA-2s are no longer to be given to the safety office



EDI Information Flow

- Employee reports the injury to his/her supervisor
- Process is started by accessing the EDI website
- Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access



EDI Information Flow

- ICPA receives an email notification of the supervisor's claim submission
- ICPA accesses the EDI application using their User ID and password
- ICPA "authenticates" the form (i.e. verifies employment status, enters appropriate codes, corrects any errors); form is then transmitted to DOL



EDI Information Flow

- If there are no problems with the claim, the ICPA will receive an email with the case number within 2-3 business days
- If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection



EDI Forms

The electronic forms can be accessed via
the ICUC website:
<http://cpms.osd.mil/icuc>

ICUC Division

Injury and Unemployment Compensation Division

- ▶ **About Injury Compensation**
- ▶ **About Unemployment Compensation**
- ▶ **Filing Claims Electronically** (supervisor's link)
- ▶ **DIUCS SSO** (password required)
- ▶ **DEFPAC** (password required)
- ▶ **FTP**



[CPMS Web Policies & Links »](#)

Welcome to ICUC

[CPMS Home](#) » [ICUC](#)

Hot Topics

Death Gratuity for Deployed Civilians

There is a new death gratuity of up to \$100,000, payable to the survivors of an employee who dies of injuries incurred in connection with service with an Armed Force in a contingency operation. Learn more about the unique requirements and procedures related to this payment.

Products & Services

- DoD Pipeline Program
- Filing Injury Claims Electronically
- Training Opportunities
- Liaison Services
- Injury Compensation (IC)
- What is DefPAC?



This DoD computer system including all related network devices (specifically including internet access) is for U.S. Government use. DoD computer systems may be monitored, including to ensure authorized use, for system management, against unauthorized access, and to verify security procedures, survivability and operational security. Monitoring includes active attacks by authorized DoD entities to test or verify the security of this system. During monitoring, information may be examined, recorded, copied and used for authorized purposes. All information, including personal information, placed on or sent over this system may be monitored. Use of this DoD computer system, authorized or unauthorized, constitutes consent to monitoring. Unauthorized use may subject you to criminal prosecution. Evidence of unauthorized use collected during monitoring may be used administrative, criminal or other adverse action.

After selecting the link, this screen will open. The user will need to read and select OK in order to continue.

OK

Cancel

ED/SaFER V1.35 07/26/06



Enter A New U.S. Department of Labor

Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

When the initial claim entry screen appears, the employee's SSN and DOB will be entered and type of claim form will be selected.

Claim Form Type

- ☒ CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
- ☐ CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Exit

EDI/SaFER V1.35 07/26/06



DIUCS v2.1 EDI

Window

ORACLE

Supervisor Entry

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN): 111-11-1111

Date of Birth (MM/DD/YYYY): 01/01/1960

Claim Form Type

☒ CA-1 Federal Employee's Notice of Traumatic

☐ CA-2 Notice of Occupational Disease and Claim

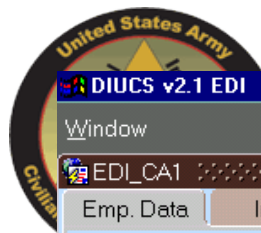
Once the employee's
information is added,
select the **Enter claim**
button to begin entering
data.

Enter claim

saf 01.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH

First Name: JOHN

Middle Name:

Suffix:

(not entered)

2. Social Security Number

111-11-1111

3. Date of birth
MM-DD-YYYY

01-01-1960

4. Sex



Male



Female

5. Home Phone

6. Grade as of date of injury

Level: WG10

Step: 05

7. Employee's home mailing address

Street Address:

City:

State:

ZIP Code:

8. Dependents



Wife, Husband



Children under 18 years



Other

Claim information

EDI claim number:

Status:

Trading partner ID:

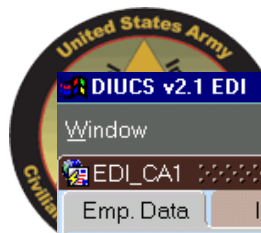
FECAEDI

Status time:

The form will now open with the employee's information populated into the appropriate fields using data from the personnel system.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH

First Name: JOHN

Middle Name:

Suffix:

(not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex



Male



Female

5. Home Phone

6. Grade as of date of injury

Level: WG10

Step: 05

7. Employee's home mailing address

Street Address:

City:

State:

ZIP Code:

8. Dependents



Wife, Husband



Children under 18 years

Claim information

EDI claim number:

Status:

Trading partner ID:

FECAEDI

Status time:

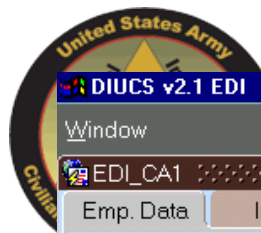
White fields are required to be filled in.

Yellow fields are optional and do not have to be filled in.

Gray fields are informational and cannot have data entered into them.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee		2. Social Security Number	
Last Name: SMITH	First Name: JOHN	111-11-1111	
Middle Name:	Suffix: (not entered)		
3. Date of birth MM-DD-YYYY 01-01-1960	4. Sex <input checked="" type="radio"/> Male <input type="radio"/> Female	5. Home Phone (123) 455-7890	6. Grade as of date of injury Level: WG10 Step: 05
7. Employee's home mailing address Street Address: City: State: ZIP Code:		8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	

Some fields require the data entered to be in a particular format. For example, phone numbers should be entered without using any () or -

Claim information	
EDI claim number:	Status:
Trading partner ID: FECAEDI	Status time:

Record: 1/1

Warning: Applet Window

Employee Information

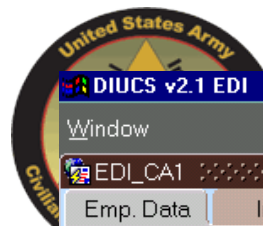
Emp. Data	Injury	Emp. Signature	Witness	Sup Rpt 1	Sup Rpt 2	Sup Rpt 3	Sup Rpt 4	Safety Data	Sup Signature
1. Name of employee Last Name: <input type="text" value="SMITH"/> First Name: <input type="text" value="JOHN"/> Middle Name: <input style="background-color: yellow;" type="text" value=""/> Suffix: <input style="background-color: yellow;" type="text" value="(not entered)"/>								2. Social Security Number <input type="text" value="111-11-1111"/>	
3. Date of birth MM-DD-YYYY <input type="text" value="01-01-1960"/>		4. Sex <input checked="" type="radio"/> Male <input type="radio"/> Female		5. Home Phone <input type="text" value="(123) 455-7890"/>		6. Grade as of date of injury Level: <input type="text" value="WG10"/> Step: <input type="text" value="05"/>			
7. Employee's home mailing address Street Address: <input type="text"/> City: <input type="text"/> State: <input type="text"/> ZIP Code: <input type="text"/>									
Claim information EDI claim number: <input type="text"/> Status: <input type="text"/> Trading partner ID: <input type="text" value="FECAEDI"/> Status time: <input type="text"/>									

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

RM-40209: Field must be of form FM9999999999999999.

Warning: Applet Window

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH

First Name: JOHN

Middle Name:

Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex



Male



Female

5. Home Phone

123456789

6. Grade as of date of injury

Level: WG10

Step: 05

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL

ZIP Code:

8. Dependents

Claim information

EDI claim number:

Status:

Trading partner ID:

FECAEDI

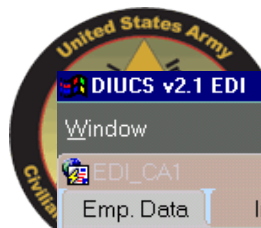
Status time:

Display List of Corresponding Zip Codes - Press CTRL + L

Record: 1/1

Warning: Applet Window

A message will also be displayed at the bottom of the screen when a dropdown box is available for a field. Fields with Zip Codes have this function. To activate the box, place the cursor in the field and hold down the CTRL and L keys at the same time.



DIUCS v2.1 EDI

Window

EDI_CA1

ORACLE

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: SMITH First Name:

Middle Name: Suffix: (not entered)

3. Date of birth
MM-DD-YYYY

01-01-1960

4. Sex

☒ Male☐ Female

5. Home Phone

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL

ZIP Code:

Claim information

EDI claim number:

Trading partner ID: FECAEDI

A box will appear that allows the available entries in that field to be searched

Listing of Zip Codes

Find FL%

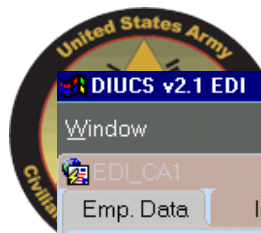
STATE	CITY	ZIP CODE
FL	FLEMING ISLAND	32006
FL	ORANGE PARK	32006
FL	BOSTWICK	32007
FL	BRANFORD	32008
FL	BRYCEVILLE	32009
FL	CALLAHAN	32011
FL	DAY	32013
FL	LAKE CITY	32024
FL	LAKE CITY	32025
FL	FLORIDA DEPT OF CORR	32026

Find OK Cancel

Choices in list: 2629

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

EDI_CA1

ORACLE

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: SMITH

First Name: JOHN

Middle Name:

Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth
MM-DD-YYYY

01-01-1960

4. Sex

☒ Male

☐ Female

5. Home Phone

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL

ZIP Code:

Claim information

EDI claim number:

Trading partner ID:

FECAEDI

Listing of Zip Codes

Find FL%

STATE	CITY
FL	FLEMIN
FL	ORANG
FL	BOSTW
FL	BRANFC
FL	BRYCEV
FL	CALLAH
FL	DAY
FL	LAKE CITY
FL	LAKE CITY
FL	FLORIDA DEPT OF CORR

Entering a state before the %
(I.e. FL%) will display all the
Zip Codes for that state

Entering a State before the %
and city after (I.e. FL%Miami)
will display all the Zip Codes for
that city.

Find

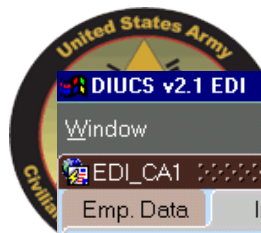
OK

Cancel

Choices in list: 2629

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL

FLEMING ISLAND FL

10. Date & time injury occurred

MM-DD-YYYY HH:MM [AM|PM]

01-20-2005 02:30 PM

11. Date of this notice

MM-DD-YYYY

01-20-2005

13. Cause of injury (Describe what happened and why)

I WAS WALKING DOWN THE STAIRS AND I TRIPP

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg)

BROKEN NOSE, BRUISED RIBS

b. OSHA Type

c. OSHA Source

Nature of Injury

Anatomical location code

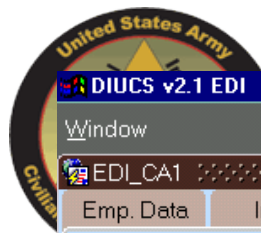
Part of Body

Side of Body

The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- ☒ a. Continuation of regular pay (COP) not to exceed 45 days beyond 45 days. If my claim is denied, I understand that I will be deemed an overpayment within the 45 days.
- ☐ b. Sick and/or Annual Leave
- ☐ c. Unknown

The employee then elects whether to use Continuation of Pay and enters the date that the claim is being entered into the EDI application.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____

Date

MM-DD-YYYY

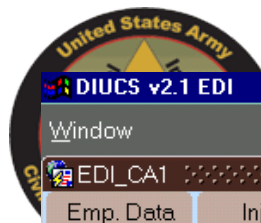
01-20-2005

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature **Witness** Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Enter a witness statement in this space. The witness will sign the statement when the claim form is printed. If there is no statement, leave this space blank.

If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information. Send the separate signed witness statement to the ICPA.

Last Name First Name Middle Name
Name of Witness: [Redacted]

Signature of witness: _____ Date signed: MM-DD-YYYY [Redacted]

Street Address: [Redacted]

City: [Redacted]

State: [Redacted] ZIP Code: [Redacted]

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

OWCP Agency Code

Agency name: GOVERNMENT AGENCY

Street Address: 123 WORK STREET

City: ANYTOWN

State: FL ZIP Code: 32006

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

☐ CSRS ☒ FERS ☐ OTHER (identify)

20. Regular work hours

HH:MM [AM|PM]

HH:MM [AM|PM]

From: 09:00 AM

To: 05:30 PM

21. Regular work schedule

☐ Sun.

☒ Mon.

☒ Tues.

☒ Wed.

☒ Thurs.

☒ Fri.

☐ Sat.

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]

Enter the required information in the appropriate fields. Paying attention to the format for data entry. (No military time)

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

Agency name: GOVERNMENT AGENCY

OWCP Agency Code

Charge Back CCPO

OSHA Site Code

OWCP District Office #

The date in Block 22 should be the same as that listed in Block 10.

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

☐ CSRS ☒ FERS ☐ OTHER (identify)

20. Regular work hours

HH:MM [AM|PM]

HH:MM [AM|PM]

From: 09:00 AM

To: 05:30 PM

21. Regular work schedule

☐ Sun.

☒ Mon.

☒ Tues.

☒ Wed.

☒ Thurs.

☒ Fri.

☐ Sat.

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

OWCP Agency Code

Agency name: GOVERNMENT

Street Address: 123 WORK STR

City: ANYTOWN

State: FL ZIP Code:

18. Employee's duty station

Street Address: GOVERNMENT

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

☐ CSRS ☒ FERS ☐ OTHER (identify)

20. Regular work hours

HH:MM [AM|PM]

HH:MM [AM|PM]

From: 09:00 AM

To: 05:30 PM

21. Regular work schedule

☐ Sun.

☒ Mon.

☒ Tues.

☒ Wed.

☒ Thurs.

☒ Fri.

☐ Sat.

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

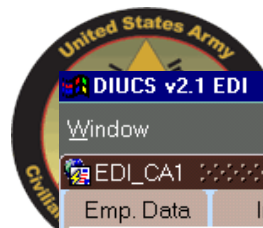
24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]

The date in Block 23 is the date the employee provided the signed claim form to the Supv or the date the employee and Supv entered the information into EDI. This date starts the "timeliness clock."

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

25. Date pay stopped
MM-DD-YYYY26. Date 45 day period began
MM-DD-YYYY27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]

28. Was employee injured in performance of duty?

☒ Yes ☐ No (If "No", explain)

If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided. Otherwise leave the box checked "yes."

If the information will not fit into this box, annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?

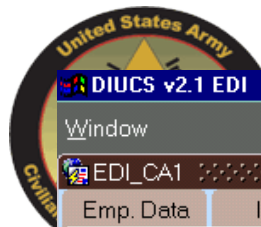
☐ Yes (If "Yes", explain) ☒ No

If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"

If the information will not fit into this box annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

30. Was injury caused by third party?

☐ Yes

☒ No

31. Name and address of third party (include city, state, and ZIP code)

3rd party name:

name continued:

Street Address:

City:

State:

ZIP Code:

Example of a third party claims would be an automobile accident in which the other driver was found to be at fault.

32. Name and address of physician first providing medical care (Include city, state, and ZIP code)

Last Name

First Name

Middle Name

Title

Street Address:

City:

State:

ZIP Code:

33. First date medical care received

MM-DD-YYYY

33a. Provided by Agency medical facility?

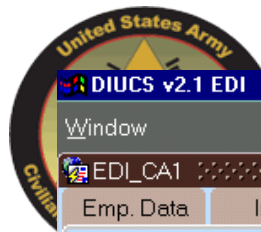
☐ Yes

☒ No

If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

☒ Yes ☐ No (If "No", explain)

If, in the investigation of the claim, nothing contradicting the employee or witness is uncovered, it would be appropriate to answer "yes". The supervisor does not have to witness the alleged incident to answer "yes".

36. If an investigation has been started, but the results are not available at the time of claim filing, then annotate "investigation in progress, results forwarded under separate cover". The ICPA should be provided with a copy of the results to forward to OWCP

37. Pay rate when employee stopped work

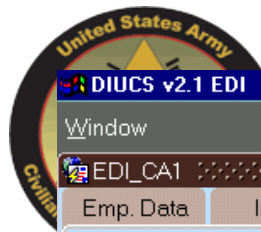
Amount:

Per:

<not entered>

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

☒ Yes ☐ No (If "No", explain)

If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space. If the information will not fit, then annotate "additional information will be forwarded under separate cover" and forward the information to the ICPA

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work

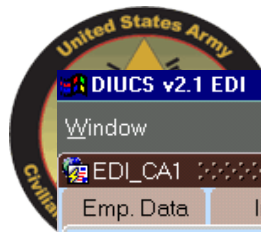
Amount:

Per:

<not entered>

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness? _____

☒ Yes ☐ No (If "No", explain)

36. If the employing agency controverts continuation of pay, state the reason in detail. _____

Enter the reason for the controversion of COP in this space.

37. Pay rate when employee stopped work _____

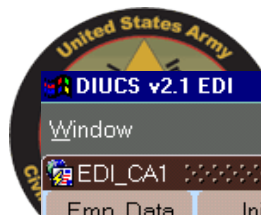
Amount:

Per:

<not entered>

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

Work Environment Exceptions

- ☐ Employee was member of general public rather than
- ☐ Injury resulted from non-work related event or exposure
- ☐ Injury resulted from voluntary participation in a work-related activity
- ☐ Injury resulted from employee eating, drinking, or
- ☐ Injury resulted from personal grooming, self medication
- ☐ Injury resulted from a motor vehicle accident occurring
- ☐ Injury is the common cold or flu.

Check all that apply for the sections on this tab. This information will be used to generate the OSHA 301 notice used for safety notification (Unique to EDI/SAFER) and will not be sent to OWCP.

Privacy Case Status:

A

Not A Privacy Case

General Recording Criteria

- ☐ Employee is deceased as a result of the incident.
- ☐ Employee suffered days away from work as a result of the incident.
- ☐ Employee's work activity was restricted as a result of the incident.
- ☒ Employee was treated in an emergency room as a result of the incident.
- ☐ Employee was hospitalized overnight as an in-patient.
- ☐ Employee lost consciousness as a result of the incident.
- ☐ Employee was transferred to another job as a result of the incident.

Preliminary OSHA Recordability

29 CFR 1960: RECORDABLE

OSHA 200 Log Coding: 6

29 CFR 1904: RECORDABLE

OSHA 300 Log Coding: J,1

Injury Classification:

A

Injury

As Of:

01-20-2005 02:53:38 PM

Record: 1/1

Warning: Applet Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

Work Environment Exceptions

- ☐ Employee was
- ☐ Injury resulted
- ☐ Injury resulted
- ☐ Injury resulted
- ☐ Injury resulted
- ☐ Injury resulted
- ☐ Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
- ☐ Injury is the common cold or flu.

Using CTRL+L when the cursor is placed in the Privacy Case Status field will display the listing of values for that field.

Privacy Case Status:

A

Not A Privacy Case

General Recording

- ☐ Employee is dec
- ☐ Employee suffer
- ☐ Employee's wor
- ☐ Employee was t
- ☐ Employee was h
- ☐ Employee lost c
- ☐ Employee was t

Injury Classification[View Claim](#)

Choose a Valid Privacy Case Code

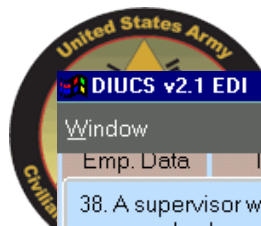
Find %

Privacy Case Description	Code
D	HIV Infection
E	Hepatitis
C	Mental Illness
G	Needlestick
A	Not A Privacy Case
H	Personal Request
B	Sexual Assault
F	Tuberculosis

Find

OK

Cancel



DIUCS v2.1 EDI

Window

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, or omission may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

If an on-site investigation was performed then a root cause will have to be entered.

Was an on-site investigation conducted?



Yes



No

What was the root cause of this injury?

Last Name

First Name

Middle Name

Name of Supervisor: SUPERVISOR

JOE

Signature of supervisor: _____

Date signed: 01-20-2005

MM-DD-YYYY

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

jsupv@govt.mil

1234567890

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

View Claim

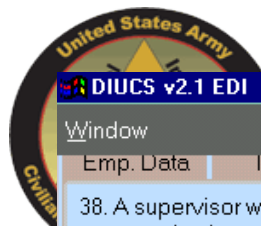
Submit Claim

Cancel

Exit

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐

Yes

☒

No

What was the root cause of this injury?

Last Name

First Name

Middle Name

Name of Supervisor: SUPERVISOR

JOE

MM-DD-YYYY

Signature of supervisor:

Date signed: 01-20-2005

Supervisor's Title

SUP

Supervisor's Email Address:

jsupv@govt.mil

Supervisor's Office phone number

1234567890

Verify the email address

39.

☐☒☐☐

Email Validation

Please re-type your email address here, before you can continue, then press OK.

jsupv@govt.mil

OK

View Claim

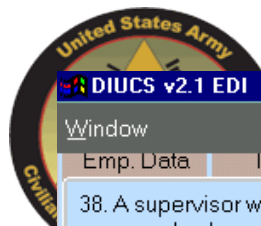
Submit Claim

Cancel

Exit

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI

Window

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?



Yes



No

What was the
root cause of

Last Name

Name of Supervisor: SUPERVISOR

Select the appropriate filing
instructions.

Signature of supervisor:

Date signed: MM-DD-YYYY

01-20-2005

Supervisor's Title

SUPERVISOR

Supervisor's Email Address:

jsupv@govt.mil

Supervisor's Office phone number

1234567890

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

View Claim

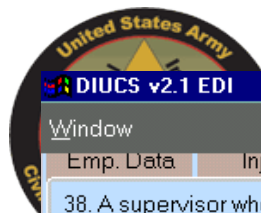
Submit Claim

Cancel

Exit

Record: 1/1

Warning: Applet Window



DIUCS v2.1 EDI



Window

ORACLE

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?



Yes



No

What was the
root cause of
this injury?

Last Name

First Name

Middle Name

Name of Supervisor:

SUPERVISOR

JOE

MM-DD-YYYY

Signature of supervisor:

Date signed: 01-20-2005

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

jsupv@govt.mil

1234567890

39. Filing Instructions

☐ No lost time and no medical expense: PI☒ No lost time, medical expenses incurred☐ Lost time covered by leave, LWOP, or C☐ First Aid Injury

Select the **View Claim**
button

View Claim

Submit Claim

Cancel

Exit

Record: 1/1

Warning: Applet Window

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Was an on-site investigation conducted?

☐ Yes

What was the

Name of Supervisor: SU

Last

Middle Name

Signature of supervisor:

Date signed:

MM-DD-YYYY

04-13-2006

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

supv@agency.gov

1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

view Claim

Submit Claim

Cancel

Exit

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

The **View Claim for Printing and Submit to ICPA** option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.

The **View Draft Copy of Claim to Verify Data** option allows the claim to be viewed and printed as a .pdf file but the user must then select the **Submit Claim** button to send the claim to the ICPA.

Signature of supervisor:

Date signed:

04-13-2006

Supervisor's Title

Supervisor's Email Address:

Supervisor's Office phone number

SUPERVISOR

supv@agency.gov

1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

View Claim

Submit Claim

Cancel

Exit



Acrobat Reader - [rwservlet[2].pdf]

File Edit Document Tools View Window Help

Print icon circled in red

Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

100036337

Employee Data

1. Name of Employee (Last, First Middle Suffix)			2. Social Security Number		
SMITH JOHN			111111111		
3. Date of Birth	4. Sex	5. Home Telephone	6. Grade as of date of injury		
01/01/1960	MALE	123456789	Level WG10 Step 05		
7. Employee's home mailing address (include city, state, and ZIP code)			8. Dependents		
123 MAIN STREET			<input type="checkbox"/> Wife, Husband		
ANYTOWN FL 32006			<input type="checkbox"/> Children under 18 year		
			<input type="checkbox"/> Other		

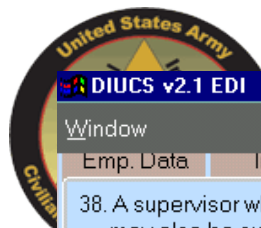
Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL
FLEMING ISLAND FL

10. Date injury occurred	11. Date of this notice	12. Employee's job title
01/20/2005 02:30 PM	01/20/2005	MAIL CLERK

13. Cause of injury (Describe what happened and why)
I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

1 of 8 10 x 11 in



DIUCS v2.1 EDI

ORACLE

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?



Yes



No

What was the
root cause of
this injury?

Last Name
Name of Supervisor: SUPERVISOR

Signature of supervisor: _____

Supervisor's Title

SUPERVISOR

If the **View Draft Copy of Claim to Verify Data** option was selected, the **Submit Claim** button must be selected on order to transmit the claim to the ICPA.

39. Filing Instructions

- ☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- ☒ No lost time, medical expenses incurred or expected: forward this form to OWCP
- ☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- ☐ First Aid Injury

View Claim

Submit Claim

Cancel

Exit

FRM-40400: Transaction complete: 1 records applied and saved.

Record: 1/1

Warning: Applet Window



Summary Of Supervisor Actions

- Supervisor selects the “Filing Claims Electronically” link on the CPMS website:
<http://cpms.osd.mil/icuc>
- Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- Employee information is entered onto the form
- Witness information is entered (if applicable)
- Supervisor enters required information in Supv portion of the form
- The form is printed. The employee, witness and supervisor sign their respective sections.
- “Submit Claim” button is selected and claim is sent electronically to the ICPA.
- Signed claim form is sent to the ICPA to be retained in the file



More information

- Contact your ICPA (Injury Compensation Program Administrator, located in the CPAC office
- Search PERMISS under OWCP & FECA
- DOD instruction 1400.25 M, subchapter 810
- Dept. of Labor's web site:

www.dol.gov/esa/regs/compliance/owcp/fecacont.htm

